

### **ROLE OF TOBACCO CONTROL LEADERSHIP**

The success of these more comprehensive Medicaid cessation benefit programs was a direct result of proactive leadership from the tobacco control programs. All six states agreed that without this leadership, the programs would be significantly less comprehensive and successful. Medicaid programs are responsible for administering and delivering a broad range of health services; a specific focus on tobacco is usually beyond their capacity. Personnel and job responsibilities can also change within the Medicaid programs. When the Medicaid tobacco champions leave or experience job changes, there can be a lapse in attention to tobacco issues.

Rather, it is the technical expertise and resources within the tobacco control programs that can remain constant, helping keep the program on track, addressing common barriers to benefit utilization and helping to design solutions. Further, the tobacco control programs may provide the primary leadership for gathering and interpreting outcome data and for helping to facilitate improvements. They all acknowledged that future and ongoing efforts from tobacco control programs, the need to “tend and maintain” partnerships, was necessary for the continued development of these Medicaid cessation benefit programs and for their ongoing success.

### **PARTNERSHIP DEVELOPMENT**

Among the six states, Medicaid partnerships followed two types of development. In the states in which the tobacco control and Medicaid programs were essentially located in the same department of state government, a close partnership existed from the beginning, usually relying on preexisting working relationships and/or directives from the agency heads. These partnerships fostered collaboration, mutual goal setting, shared resources, and shared outcomes. In the states in which the tobacco control efforts were more separate from the Medicaid programs, the tobacco control programs tended to take the initiative for coordinating activities to improve outreach to Medicaid providers and recipients, designed systems to increase use of the benefit, and took the lead in developing Medicaid partnerships. Both models were successful but illustrate different pathways to developing partnerships.

An additional factor in partnership development is the political circumstances in each state. As the state political administrations change, Medicaid administration can change and priorities can change. Budget crises often affect Medicaid, and tobacco control programs often forcing the need to reprioritize. Sustaining partnerships through political, administrative, and budget changes can be challenging.

### **QUALITY IMPROVEMENT**

The quality improvement process was dependent on the way tobacco control programs provided leadership and was shaped by the nature of the partnership. In the states with close partnerships, the working relationships themselves were often a significant source of quality improvement. The formal and informal working relationships provide multiple opportunities for sharing information and resources and helped to shape mutual decisions to undertake innovations and improvements in the program. In the states where the programs were more separate, process and outcome data was more often used to measure progress and reset goals. In all cases, as the tobacco control program became more expert in the complexities of the Medicaid system, they were able to provide increasing levels of the technical assistance and partnership necessary for effective quality improvement.

An important aspect of quality improvement that was reported in the case studies was the role of regular meetings and communication. Each state has a meeting schedule with the Medicaid programs. In some states (e.g.: Utah, New York) the tobacco control program has regular meetings of

their tobacco cessation staff that Medicaid representatives attend. These reporting and problem solving meetings help share information between programs and identify quality improvement steps. In other states, tobacco control staff attend regular Medicaid meetings (Oregon, Oklahoma, Wisconsin), report on tobacco outcomes, and discuss quality improvement. In Minnesota, this discussion is part of the regular Quitline Collaborative meetings.

## **QUITLINE DATA**

All the states use their quitline data, broken down by insurance coverage, to illustrate the reach of tobacco control sponsored services and to make decisions about promotion and management. In Oregon and Utah, Medicaid reimburses for counseling and pharmacotherapy services through the quitline (and/or through participating health plans), so quitline data is an important measure of utilization. In Minnesota, most health plans provide quitline services to all members, including Medicaid recipients, so quitline data illustrates the reach of their plan covered services. In New York, Medicaid recipients can receive nicotine replacement therapy as a covered benefit through their health plan or they can receive it directly from the quitline. The quitline is heavily promoted making the quitline data in New York an important indicator of utilization. In Wisconsin and Oklahoma, the quitline is heavily promoted throughout the state together with promotion of the pharmacotherapy benefits available through Medicaid. Again, number of calls to the quitline is used as an indicator of reach into the whole population, including the Medicaid population.

## **PARTNERSHIPS TO OVERCOME BARRIERS TO UTILIZATION**

Several common barriers to utilization were described; lack of awareness about the existence of the benefit, lack of clarity about the specifics of the benefit coverage, and lack of attention to outcomes. The partnerships between the Medicaid and tobacco control programs helped design solutions. For example, to address lack of awareness of the existence of the benefit among health care providers and Medicaid recipients, promotion efforts designed by the tobacco control programs included benefit information mailed with Medicaid eligibility cards (Oregon, Oklahoma, Utah) and benefit information disseminated via academic detailing (New York, Wisconsin). To address the lack of clarity about the details, tobacco control programs (New York, Wisconsin, Utah) developed fact sheets, hotlines, and other tools to accurately communicate these details and devised outreach strategies to make them available. To address the lack of attention to outcomes, tobacco control programs helped gather, analyze, and review program utilization data (Oregon, Oklahoma, Utah) subsequently prompting Medicaid programs to make changes in the quality of how they administer their benefits. In most of these examples, improvements came as a result of better coordination of existing resources between tobacco control programs and Medicaid programs and the ability of the tobacco control programs to both devise and recommend innovations. In all cases, leadership and support from tobacco control programs was essential.

## **MEDICAID “BENEFIT” VS. MEDICAID “PROGRAM”**

All states described a benefit implementation process that requires an active, ongoing, and coordinated communication and education program. Unlike other benefits that are activated when patients seek help for illnesses, the tobacco cessation benefit requires a more proactive and coordinated approach to be effective. In this way, the “benefit” may be better understood as a “program service,” requiring more active planning, coordination, and evaluation. This distinction is especially important for improving utilization, since ongoing promotion and quality improvement is necessary to increase use of services.

## **MEDICAID AS PART OF A LARGER STATE NETWORK OF PUBLIC SERVICES**

Medicaid programs are usually situated within a network of public state services. Improving benefits provided through Medicaid programs has the direct effect of improving services to Medicaid

recipients and an indirect “ripple” effect by influencing other public services provided through other state agencies. For example, benefits developed for the Oklahoma Medicaid program were subsequently extended to recipients of their low-income and small business insurance plan and influenced negotiations about benefits for state employees. In Oregon, where Medicaid benefits have been established for a decade, a collaboration is underway to merge systems between the Medicaid program and mental health program to permit mental health treatment specialists to be reimbursed for tobacco dependence treatment under the Medicaid rules, thus extended improved services for mental health consumers. Because of these relationships, the effort to develop partnerships between tobacco control and Medicaid programs can have a broader impact in a state, especially for people dependent on public services.

## **SUMMARY FOR TOBACCO CONTROL PROGRAMS**

1. Be proactive. Proactive leadership is needed for developing better partnerships and to help with development, implementation and quality improvement of Medicaid benefits. The case studies show that an ongoing focus and technical support from tobacco control programs is needed for Medicaid programs to succeed. Working relationships between high level program managers and administrators are needed along with opportunities to provide information and resources to Medicaid programs. The case studies in this Report can help with developing partnership strategies.
2. Be knowledgeable about Medicaid. Medicaid programs rely on tobacco control programs for technical information and support about tobacco cessation and for help integrating tobacco cessation services into Medicaid programs. To be more effective, tobacco control programs need to be familiar enough with Medicaid programs to “speak the same language.” It will help to learn:
  - a. The basic outline of the federal/state Medicaid requirements.
  - b. The number of people enrolled in Medicaid in your state.
  - c. The mix of managed care and fee-for-service providers in your state.
  - e. A basic understanding of how managed health care works and about managed care quality improvement.
  - f. The cessation benefits and services currently provided through Medicaid and how they are reimbursed.
  - g. The meeting structure within Medicaid and where you can become involved.
  - h. How Medicaid quality improvement is handled.
  - i. The current political environment for the Medicaid program—where the priorities are.
  - j. What the needs are in your Medicaid program and which best practices from other states can help.
3. Approach changes in incremental steps. Every change to the Medicaid system is difficult and time consuming. Changes may have to be approved by multiple groups and, if there are budget implications, by the state legislature. Learn the process for making changes, help prioritize, and help support implementation. Be patient. Medicaid partnerships can be disrupted by changes in personnel, political changes in the administration, and changes in priorities.
4. Explore quitline/Medicaid partnerships. Quitlines are a primary source of tobacco cessation services in any state. Explore how quitline services and quitline data can be used to strengthen